The Florida Legislature

OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY

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RESEARCH MEMORANDUM

Expanding Scope of Practice for Advanced Registered Nurse Practitioners, Physician Assistants, Optometrists, and Dental Hygienists

December 30, 2010

Summary

As requested, OPPAGA examined the implications of expanding particular aspects of the scope of practice for three groups of health care practitioners: advanced registered nurse practitioners (ARNPs) and physician assistants (PAs); optometrists; and dental hygienists. Scope of practice laws detail the services that health professionals are authorized to offer and the settings in which they can practice. Our research addressed the following issues.

- For ARNPs and PAs, differences between Florida's scope of practice laws and those of other states, arguments for and against expanding the scope of practice, and the potential cost savings from greater use of ARNPs and PAs in primary care.
- For optometrists, differences between Florida's laws and those of other states in authorizing optometrists to prescribe oral medications, arguments for and against revising prescription authority, and the potential cost savings and effect on health care access for Medicaid participants if Florida authorized optometrists to prescribe oral medications.
- For dental hygienists, differences between Florida's laws and those of other states in authorizing hygienists to provide preventive dental care without dentist authorization, arguments for and against authorizing dental hygienists to practice more independently, and the potential effect on access to preventive dental care for Medicaid participants if dental hygienists practiced more independently.

Advanced Registered Nurse Practitioners and Physician Assistants

Unlike most other states, Florida does not allow ARNPs and PAs to prescribe controlled substances. States vary in authorizing ARNPs and PAs to directly bill insurance companies and managed care organizations; Florida law neither prohibits nor requires insurance companies and managed care companies to allow ARNPs and PAs to bill them directly. Opponents of expanding the scope of practice of ARNPs and PAs cite concerns about patient safety. Proponents assert that these practitioners are qualified to prescribe such medications and expanding scope of practice would increase access to health care. OPPAGA's estimates of potential cost-savings from expanding ARNP and PA scope of practice range from $7 million to $44 million annually for Medicaid, $744,000 to $2.2 million for state employee health insurance, and $339 million across Florida's health care system.

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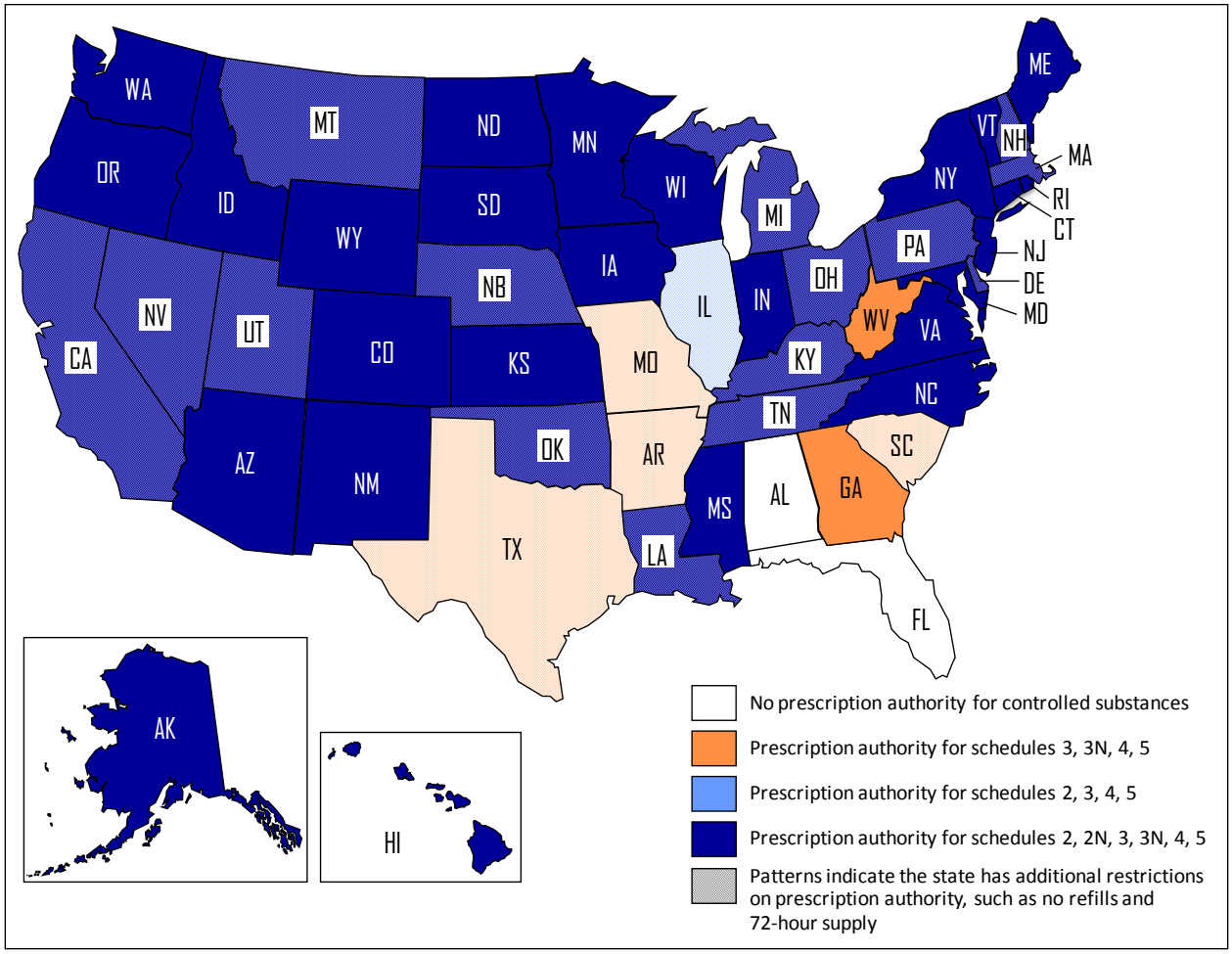
Several factors could affect implementation and the time needed for ARNPs and PAs to assume more responsibility for providing primary care services. These factors include the need for the Department of Health to promulgate rules, the need for the health care industry and providers to change billing practices, and patients' willingness to receive treatment from these practitioners instead of physicians.

How do Florida's laws differ from those of other states regarding scope of practice of ARNPs and PAs?

Florida is one of two states that do not allow ARNPs or PAs to prescribe controlled substances. Alabama and Florida do not allow ARNPs to prescribe controlled substances, and Kentucky and Florida do not allow PAs to prescribe controlled substances. As shown in Exhibits 1 and 2, the remaining states have granted ARNPs and PAs this authority to varying degrees.

Exhibit 1
Florida is One of Two States that Do Not Allow Advanced Registered Nurse Practitioners (ARNPs) to Prescribe Controlled Substances[1, 2]

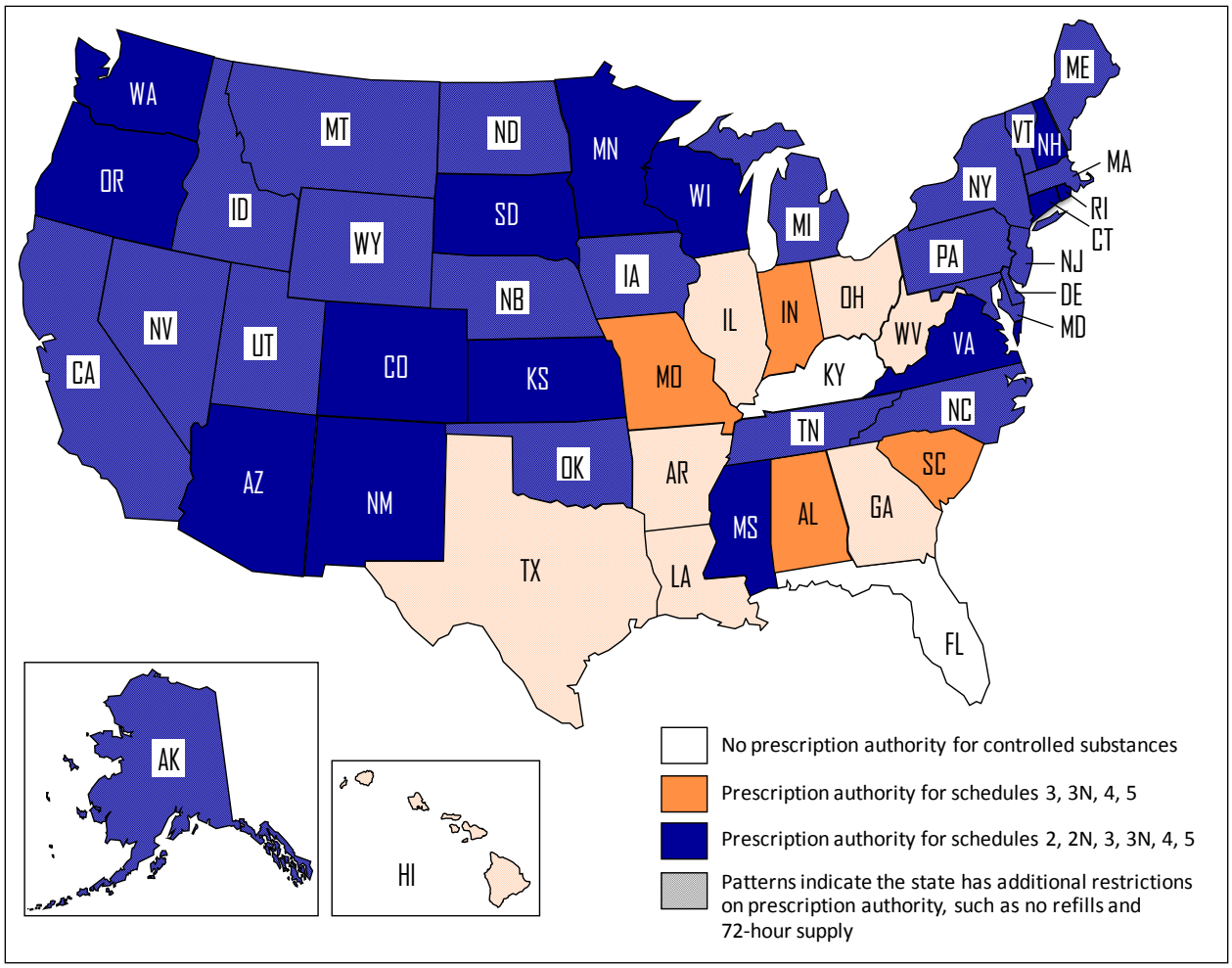


[1] The drugs and drug products considered controlled substances are categorized into five schedules. For more information on the schedules, see: www.deadiversion.usdoj.gov/drugreg/practioners/index.html.

[2] Hawaii and Missouri are in the process of promulgating rules authorizing ARNPs to prescribe controlled substances.

Source: U.S. Department of Justice, Drug Enforcement Administration.

Exhibit 2
Florida is One of Two States that Do Not Allow Physician Assistants (PAs) to Prescribe Controlled Substances[1]



[1] The drugs and drug products considered controlled substances are categorized into five schedules. For more information on the schedules, see: www.deadiversion.usdoj.gov/drugreg/practioners/index.html.

Source: U.S. Department of Justice, Drug Enforcement Administration.

Florida law neither prohibits nor requires insurance companies to allow direct billing for ARNPs and PAs; other states' laws vary widely on whether and how they address this issue. Information from the American Academy of Physician Assistants on 33 states' statutes and rules shows that 9 other states have statutory language similar to Florida, while 5 states have language allowing direct billing by physician assistants. In three of the states that authorize direct billing, the provisions only apply to the Medicaid program. Another 19 states specifically prohibit PAs from billing for services. Managed care organizations' billing policies generally reflect the scope of practice provisions of their states. Managed care organizations in states that allow ARNPs to practice independently typically allow ARNPs to directly bill.[1]

[1] A 2007 survey of managed care organizations in the United States found that in states requiring no physician involvement for ARNPs to prescribe, 71% of managed care organizations allow ARNPs to directly bill as providers in their networks. In states that require physician collaboration for ARNPs to prescribe, as in Florida, 50% of managed care organizations allow ARNPs to directly bill as providers in their networks.

Prescribing and billing practices can affect the extent to which ARNPs and PAs can practice independently of physician supervision. Although some ARNPs in Florida establish their own primary care practices, statutes require that they do so under an agreement with a physician to provide supervision. Alternatively, ARNPs and PAs often practice within physicians' offices. In either instance, the physician establishes the level of supervision other than prescription of drugs, such as whether the physician will be consulted on decisions involving patient care, will review and approve some or all patient medical charts, or will be involved in approving patient care decisions to varying degrees based on types of illnesses and treatments.

What are arguments for and against expanding the scope of practice for ARNPs and PAs?

Opponents. Arguments against expanding the scope of practice for ARNPs and PAs are primarily related to patient safety. Opponents, which include health care provider groups, cite differences in the education requirements of physicians versus ARNPs and PAs, and conclude that these health care professionals do not have sufficient training and medical education to safely practice more independently. These stakeholders believe that physicians are the only professionals capable of properly diagnosing the array of possible patient medical conditions, weighing patients' medical histories (including other conditions and existing medications), and determining whether a controlled substance is appropriate and can be prescribed safely. This is because controlled substances can mask underlying conditions, result in serious drug interactions, and/or lead to addiction. In addition, opponents argue that because ARNPs and PAs lack adequate education and training, practicing without the current level of physician supervision could lead to delays in diagnosing serious conditions, as well as higher utilization and costs due to more frequent referrals for diagnostic and other services.

Proponents. Stakeholders who favor expanding the scope of practice for ARNPs and PAs believe that patient safety would not be compromised. Some ARNPs and PAs assert that they have sufficient training and education to safely prescribe controlled substances and practice more independently. They also cite research that shows similar or better patient outcomes for care provided by ARNPs and PAs compared to outcomes for care provided by physicians. For example, an October 2008 study found that after adjusting for a variety of indicators of patient complexity, adults who exclusively visited physician assistants for 30% or more of their health care had an average of 16% fewer visits per year.[2]

Proponents also believe that expanding scope of practice would increase access to health care. About 70% to 80% of nurse practitioners work in primary care, which includes pediatrics, adult health care, gerontology, and nurse midwifery. A 2008 U.S. Government Accountability Office study reported that the per capita supply of nurse practitioners annually increased by an average of 9% over a 10-year period. In contrast, a recent survey of medical school graduates showed that only 2% were choosing to work in primary care, in part due to high educational debt and low salaries relative to more lucrative medical specialties. Proponents also believe that expanding scope of practice would improve choice for patients interested in seeing ARNPs or PAs as primary care providers and facilitate ARNPs' and PAs' inclusion in managed care organization provider directories.

[2] Morgan, P.A. (2008). Impact of Physician Assistant Care on Office Visit Resource Use in the United States. *Health Services Research*, 43(5), 1906-1922.

What are the potential cost savings from greater use of ARNPs and PAs in primary care?

OPPAGA's estimates of potential cost savings from expanding scope of practice in primary care range from $7 million to $44 million annually for Medicaid, $744,000 to $2.2 million for state employee health insurance, and $339 million across Florida's entire health care system. Several factors could affect the implementation and time needed to achieve these savings.

We used three methods to estimate the potential cost savings from greater use of ARNPs and PAs in primary care based on differences in the reimbursement rates for their services compared to those of physicians. Insurance companies and the Medicaid and Medicare programs often realize cost savings by reimbursing services provided by ARNPs and PAs at a lower rate than services provided by physicians. For example, Florida's Medicaid program pays an average of $40 for primary care office visits with ARNPs or PAs, compared to $49 for office visits with physicians.

Method 1: Savings of an estimated $7 million in annual appropriations for Medicaid and $747,000 in annual appropriations for state employee health insurance. Our first method focused on providing a somewhat conservative estimate of state savings (both general revenue and trust funds) for the Medicaid and state employee health insurance programs. This method assumes that ARNPs and PAs would assume responsibility for most of the primary care office visits for conditions similar to those treated in retail clinics. To derive this estimate, we modified a technique used in a 2009 RAND Corporation report that described various ways the Massachusetts could control its health care spending.[3] RAND used survey data to estimate the number of office visits in the state related to cough, earache, fever, nasal congestion, skin rash, and throat symptoms, which RAND analysts chose because these are frequently the types of symptoms for which patients visit retail clinics and receive services from ARNPs and PAs. RAND determined the number of office visits in which physicians treated similar symptoms, and estimated the cost savings if these services had instead been provided by an ARNP or PA.

To apply this method to Florida, we used fee-for-service claims data for participants in Florida's Medicaid program and active employees in the state employees' health insurance program, which resulted in estimated reductions of $7 million in Medicaid and $747,000 in state employee health insurance annual spending.[4] Of this amount, we estimated that the state would save $3.2 million in general revenue funds for the Medicaid program; we could not develop a similar estimate for the state employees' health insurance program.[5] Although similar savings may be achieved in these programs' managed care plans, we could not provide a savings estimate because Medicaid has only recently begun collecting encounter data on managed care office visits, and a similar data system does not exist for state employee health insurance.[6]

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[3] Eibner, C.E., Hussey, P.S., Ridgely, M.S., & McGlynn, E.A. (2009). *Controlling health care spending in Massachusetts: An analysis of options*. (Publication No. 09-219-HCF-01). Boston, MA: RAND Corporation.

[4] We excluded Medicare eligible participants, early retirees, and Consolidated Omnibus Budget Reconciliation Act (COBRA) participants because the state does not cover the full cost of these claims. For Medicare eligible individuals, Medicare is their primary insurance coverage and the state plan only covers remaining costs. Early retirees and COBRA participants pay the full cost of their health insurance premiums.

[5] We estimated the general revenue savings for Medicaid using the Federal Medical Assistance Percentage of 56.04% for Federal Fiscal Year 2011. The state employees' health insurance trust fund is funded primarily by premiums paid by subscribers and employers. Employers use various funding sources to pay for salary and benefits; thus, the amount of general revenue used to pay premiums varies by employer.

[6] Approximately one-third of Medicaid enrollees and 44% of state employees receive health care through a managed care health plan.

Method 2: Maximum savings of an estimated $44 million in annual appropriations for Medicaid and $2.2 million in annual appropriations for state employee health insurance. Our second method focused on the maximum, upper range of state savings, assuming that ARNPs and PAs would take responsibility for a substantial portion of office visits in primary care settings. For this estimate, we used the fee-for-service claims data from the Medicaid and state employee health insurance programs. We first identified those primary care office visit procedure codes that were performed by physicians, and by ARNPs and PAs.[7] We then developed an average cost per procedure for ARNPs and PAs. Finally, we calculated the difference between the physicians' cost and the average ARNP and PA cost for each primary care physician claim. The sum of these differences represents estimated savings of approximately $44 million annually in Medicaid costs and $2.2 million annually in state employee health insurance costs.[8, 9] Of these amounts, we estimated that the state would save $19.5 million in general revenue funds for the Medicaid program; we could not develop a similar estimate for the state employees' health insurance program.

Estimates based on the first two methods have some limitations. Savings would accrue gradually over time due to the time required for ARNPs and PAs to be given more responsibility for these office visits. In addition, ARNPs and PAs likely would not assume responsibility for all of these office visits. Currently, they conduct 0.1% of the primary care office visits for state employees and 8.7% of the primary care office visits for Medicaid participants. Further, the estimates from the second method ($44 million for Medicaid and $2.2 million for state employee health insurance) are maximum estimates of the potential for cost savings.

Method 3: Maximum savings of an estimated $339 million in annual savings across Florida's health care system. We could not verify a stakeholder estimate that the potential savings for all payers of primary care in Florida would be $1 billion because the estimate was not based on statewide claims data, and other aspects of the estimate were based on assumptions and professional judgment. We therefore used the data from our second analysis of state employee health insurance claims to attempt to validate the upper range of savings across Florida's health care system. We applied the estimated savings percentage from Method 2 to information provided by the federal Agency for Healthcare Research and Quality, which used survey data to estimate the cost of all primary care office visits in Florida.[10] After adjusting for differences in age groups, we estimated that Floridians and entities, such as employers, that pay for health care could save a maximum of $339 million annually if ARNPs and PAs conducted all primary care office visits.[11]

As with the Medicaid program and state employee health insurance program savings estimates, this estimate is a maximum estimate of the potential for cost savings, and has limitations.

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[7] For this analysis, we considered physicians as primary care providers if their specialty was adult primary care, family practice, general practice, geriatrics, gynecology, internal medicine, obstetrics, obstetrics-gynecology, and pediatrics,

[8] As with the first method, this analysis only included participants in Medicaid fee-for-service programs, and excludes Medicare eligible individuals, early retirees, and COBRA participants from the state employee insurance population.

[9] Our analysis of state employee health insurance claims fee-for-service data base showed that costs of visits to ARNPs and PAs were 8.5% less than physicians.

[10] The federal Agency for Healthcare Research and Quality compiles an annual survey, the Medical Expenditures Panel Survey, from different sources to analyze national health care costs and other factors. The Agency for Healthcare Research and Quality provided data on the frequency and cost of primary care office visits in Florida.

[11] We weighted the estimate for age groups to account for the higher concentration of elders statewide than was included in state employee health insurance fee-for-service claims data.

Savings would accrue gradually over a long period due to the time required for ARNPs and PAs to take responsibility for these office visits. Also, ARNPs and PAs likely would not assume responsibility for all of these office visits.

Several factors could affect the implementation and the time needed for ARNPs and PAs to assume primary care services. Changing the scope of practice for ARNPs and PAs would require the Department of Health to promulgate administrative rules to implement these changes, which could take over a year.[12] Florida administrative laws require agencies to obtain input from stakeholders and hold public rule workshops, which can delay promulgation of rules that may be controversial or contentious. Although some states have promulgated rules to implement changes in ARNP or PA scope of practice quickly, others have experienced delays. Exhibit 3 lists states that have granted ARNPs and PAs controlled substance prescription authority since 2005, the effective date of the statutory authority, and the date rules were promulgated. In half of these instances, it took over a year to promulgate the necessary rules.

Exhibit 3
The Time to Promulgate Rules to Implement Changes in ARNP and PA Controlled Substance Prescription Authority Varies Across States

	State	Effective Date of Statutory Authority	Date Rule Promulgated
Advanced Registered Nurse Practitioners (ARNPs)	Hawaii	July 2, 2009	Not yet promulgated
	Kentucky	July 12, 2006	August 2006
	Missouri	June 10, 2008	Not yet promulgated
Physician Assistants (PAs)	Alabama	October 1, 2009	March 24, 2010
	Indiana	July 1, 2007	May 5, 2010
	Missouri	August 28, 2009	Accomplished without rule
	New Jersey	September 17, 2005	June 2, 2008
	Ohio	May 17, 2006	October 31, 2007

Source: OPPAGA analysis of state laws and rules.

Expanding ARNP and PA scope of practice would also require changes in both industry and provider billing practices. Under Medicare, Medicaid, and private insurance, patient visits to ARNPs and PAs can be billed at 100% of the physician reimbursement rate if directly supervised by the physician and billed under the physician's provider number with the physician as the treating provider; this is referred to as "incident-to" billing in Medicare. To maximize cost savings, ARNPs and PAs would need to stop billing for services under their supervising physician's billing number and instead bill under their own provider numbers. This change would be difficult to mandate within a physician's practice because physicians decide the protocol for their degree of involvement in office visits that occur within their practices and for other supervisory agreements. These protocols are determined by the physician's professional judgment.

Another factor that could affect potential cost savings is that some patients may be reluctant to see an ARNP or PA instead of a physician for primary care. A 2004 study found that on average, ARNPs and PAs attended 33% of adult visits and 20% of pediatric visits.[13]

[12] The time frame required for rule adoptions referenced in this memo may also be affected by CS/CS/HB 1565, enacted during the 2010 Regular Session of the Legislature, and made effective November 17, 2010 by HJR 9A, the veto of the Governor notwithstanding.
[13] Roblin, D. (2004). Use of midlevel practitioners to achieve labor cost savings in the primary care practice of an MCO. *Health Care Economics*, 39(3), 607-625.

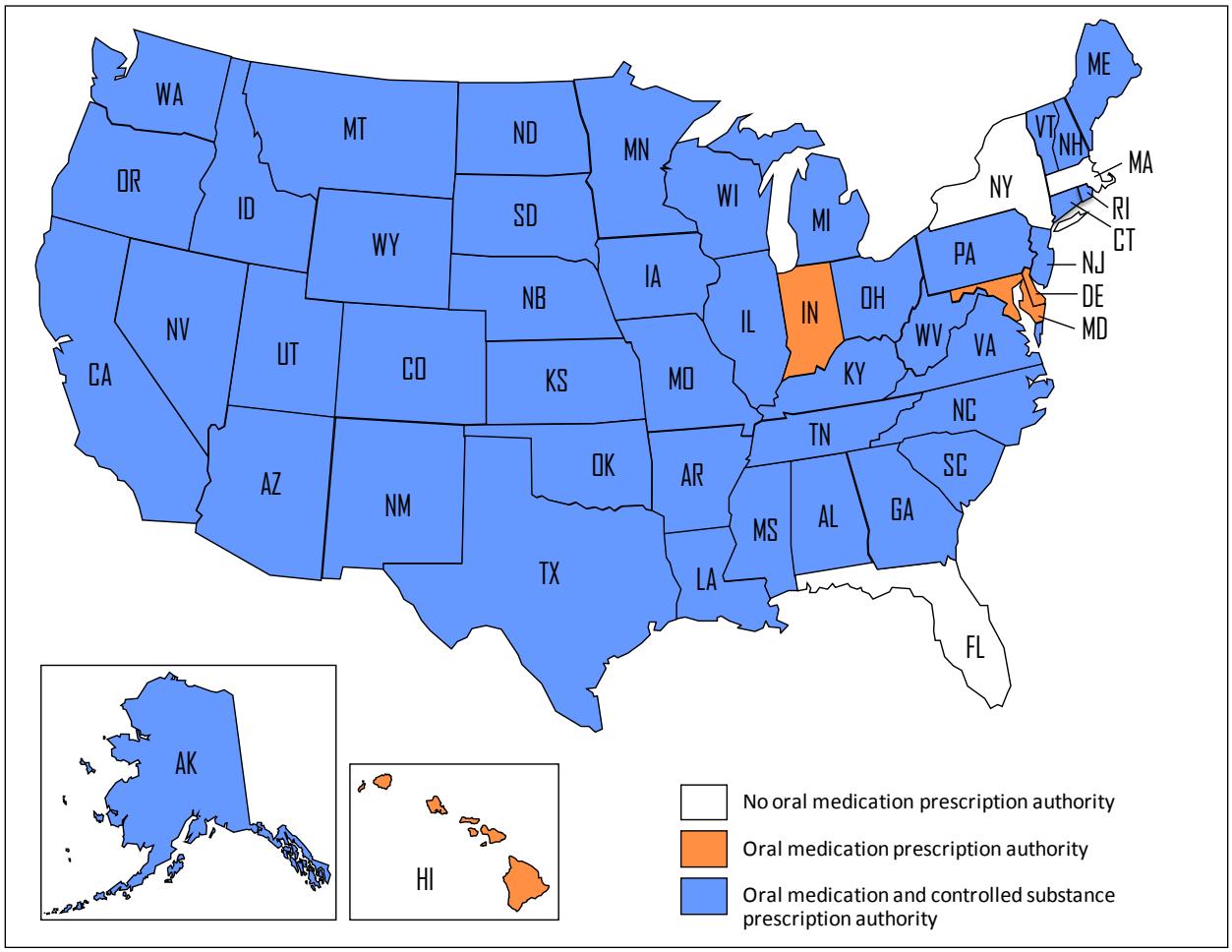
Optometrists

While most other states authorize optometrists to prescribe oral medications and controlled substances, Florida does not. Opponents' arguments against giving optometrists this authority primarily relate to patient safety. Proponents' arguments include cost savings due to less frequent referrals to ophthalmologists and increased patient access to eye care. Our analysis found minimal cost savings to the state as a result of expanding optometrists' prescription authority. However, making this change may enhance Medicaid participants' access to eye care. Florida's administrative rule promulgation process would affect the length of time needed to implement changes to optometrists' prescription drug authority.

How do Florida's laws differ from those of other states in authorizing optometrists to prescribe oral medications?

Florida is one of three states that do not authorize optometrists to prescribe oral medications for their patients. In addition, 43 of the 47 states that grant optometrists this authority also allow them to prescribe controlled substances, as shown in Exhibit 4. In Florida, certified optometrists may only prescribe topical eye medications. If an optometrist diagnoses a condition that would be best addressed with an oral medication, the patient must see another practitioner, such as an ophthalmologist, for treatment.

Exhibit 4
Florida is One of Three States that Do Not Authorize Optometrists to Prescribe Oral Medications[1]



[1] Oral medications that are prescribed to patients for eye care include antibiotics, steroids, antivirals, and pain medication.
Source: Florida Optometric Association.

What are arguments for and against revising optometrists' prescription authority?

Opponents. Stakeholders opposed to giving optometrists more prescription authority, which include health care provider groups, argue that optometrists do not have sufficient training and medical education to safely prescribe oral medications, including controlled substances, and that only physicians are sufficiently trained to make safe medication decisions. These opponents contend that Florida's large elder population makes comparisons to other states' prescription authority policies problematic. Opponents also maintain that giving optometrists more prescription authority would increase the risk of misdiagnosis or delayed diagnosis of serious problems. Further, in many situations, opponents argue that an additional visit to an ophthalmologist or other licensed physician is inevitable. For example, when a patient is diagnosed with glaucoma, the optometrist is required by law to refer the patient to a physician.

Proponents. Stakeholders in favor of granting optometrists more prescription authority cite cost savings from fewer referrals to ophthalmologists and increased access to eye care for underserved populations, such as Medicaid participants in rural areas. These stakeholders argue that optometrists receive sufficient training, including coursework in systemic pharmacology required for licensure and continuing education, to safely prescribe oral medications. They also assert that patients would be less likely to need a second office visit with another health care professional for treatment with oral medications. In addition, they note that optometrists in Florida's federally-operated Veterans' Affairs hospitals are authorized to prescribe oral medications.[14] Proponents also state that the limited availability of ophthalmologists who participate in Medicaid restricts patient access to needed eye care and therefore compromises patient safety. They contend that while a patient waits for an ophthalmologist to become available, an eye condition can become more severe. Although patients may be able to visit other types of practitioners for prescriptions, such as primary care providers, these providers often do not have the equipment needed to diagnose eye conditions.

What are the potential cost savings and effect on health care access for Medicaid participants if Florida authorized optometrists to prescribe oral medications?

Potential cost savings may be minimal. Our analysis showed minimal potential cost savings from avoiding a subsequent office visit to an ophthalmologist because there were relatively few ophthalmologist office visits that resulted from an optometrist referral in which the ophthalmologist prescribed medications. We identified 499 Medicaid beneficiaries and state employees who may have received such a referral over the course of a year. If these referrals had not occurred, the state would have saved approximately $10,000 in claims.

To assess potential state cost savings, we analyzed fee-for-service claims data for the state Medicaid program and active employees in the state employees' health insurance program. Our methodology identified all Medicaid participants who visited an ophthalmologist within 60 days of visiting an optometrist and state employees who visited an ophthalmologist within 30 days of visiting an optometrist. (We used different periods for the two programs after asking program administrators for conservative estimates of the time patients may need to wait for an appointment with an ophthalmologist.) From these individuals, we then identified those that received a prescription for an oral medication within one week after visiting an ophthalmologist. Based on the total cost of the ophthalmologist claims, we estimated that authorizing optometrists to prescribe oral medication would result in $10,000 in potential cost savings.

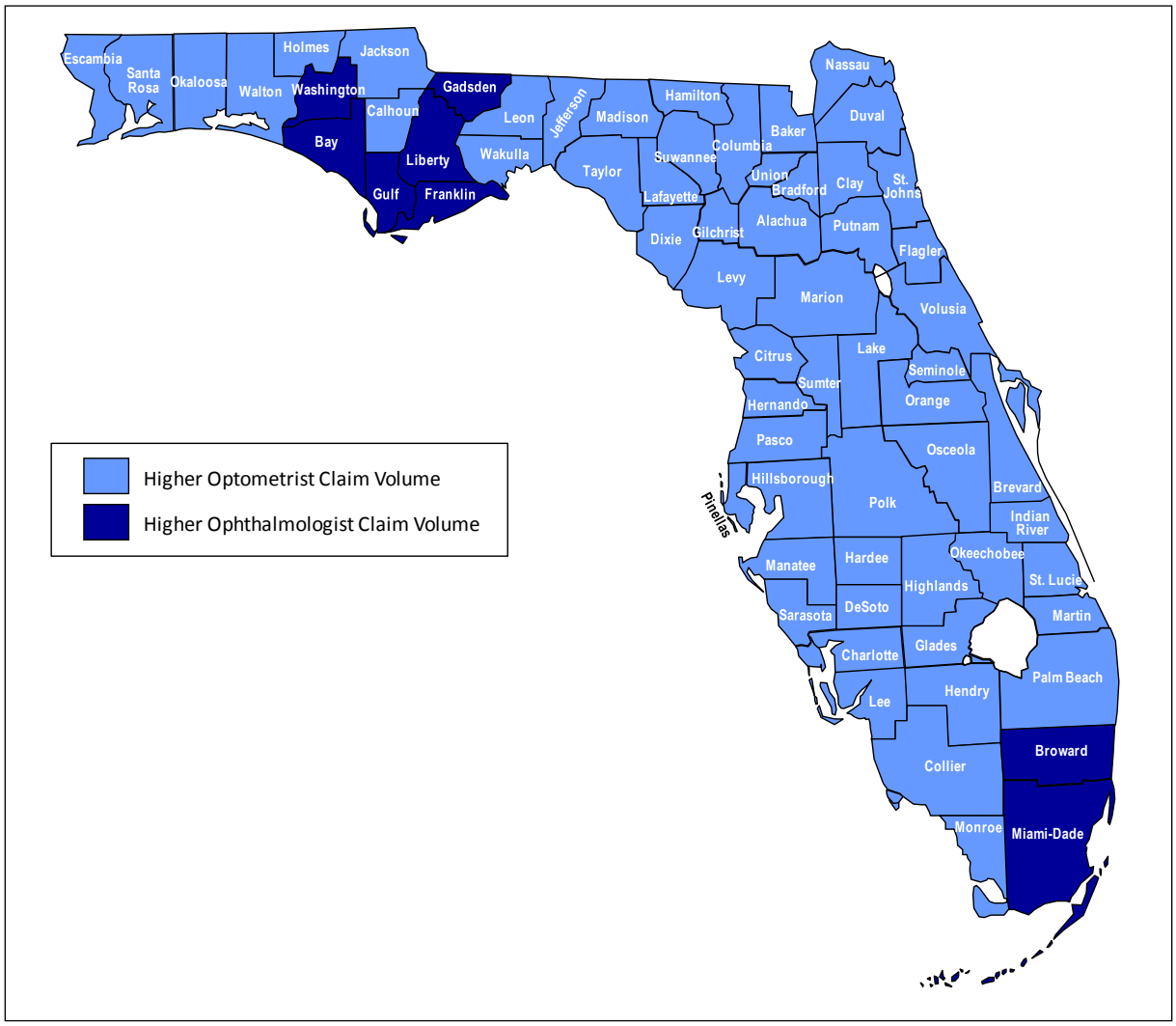
Our analysis had some methodological and data limitations. Patients may have been able to see a practitioner other than an ophthalmologist. We could not assume there was a link between an optometrist office visit and an office visit to any other practitioner within 30 to 60 days; therefore, we did not include all possible types of practitioner office visits in our analysis. In addition, employees in the fee-for-service portion of the state employees' health insurance program have other options for eye care, including supplemental vision coverage and an additional network of vision services providers who will provide a 20% discount on materials and services paid out-of-pocket by subscribers. According to program administrators, if

[14] According to the U.S. Department of Veterans Affairs (VA), 42 optometrists in Florida's VA hospitals are allowed to prescribe oral medications. The department's policy is that if optometrists are licensed in another state that gives them oral medication prescription authority, then VA hospitals can approve optometrists for writing prescriptions for oral medications.

employees see an optometrist under one of these options, they often pay the cost of the office visit themselves and do not generate a claim. Further, our analysis of claims data did not include participants in managed care plans.

Medicaid participants could have greater access to eye care. Authorizing optometrists to prescribe oral medications could provide Florida Medicaid participants additional options for eye care. As shown in Exhibit 5, in 59 of 67 (88%) of Florida's counties, optometrists submitted more Medicaid claims than ophthalmologists during Fiscal Year 2008-09.[15]

Exhibit 5
Optometrists Submitted More Medicaid Claims than Ophthalmologists in 59 Counties



Source: OPPAGA analysis of Medicaid data.

[15] We could not make county comparisons of the number of optometrists and ophthalmologists who provide services to Medicaid participants because not all Medicaid providers have unique provider identifiers.

Rule promulgation would affect how quickly changes in optometrist prescription authority could be implemented. It may take over a year to complete rule promulgation to address a change in optometrists' prescription authority. Florida administrative laws require agencies to obtain input from stakeholders and hold public rule workshops, which can delay promulgation of rules that may be controversial.

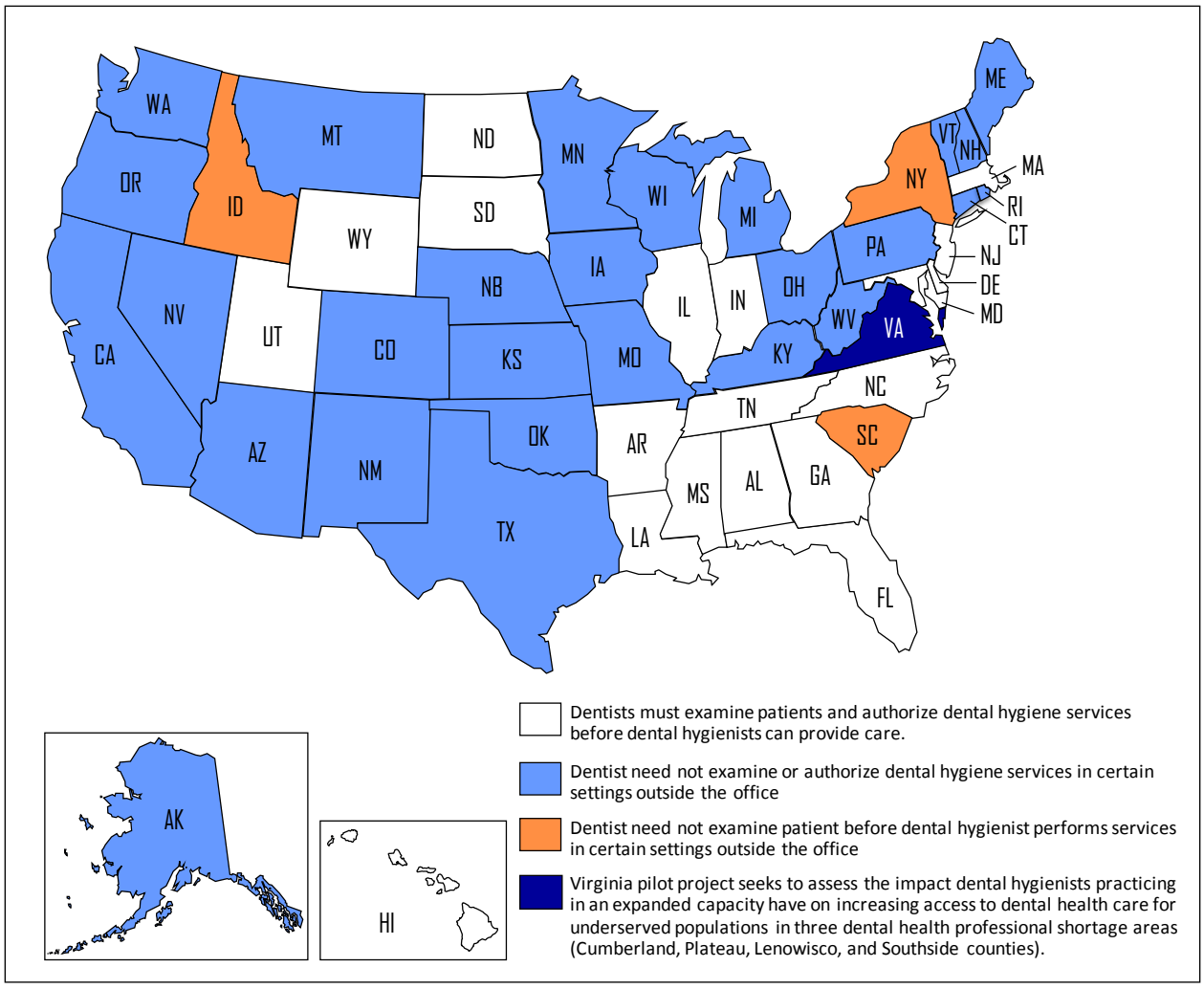
Dental Hygienists

Thirty states allow dental hygienists to initiate patient treatment, such as cleanings, without the specific authorization of a dentist, but Florida does not allow dental hygienists this level of independence. Opponents of allowing dental hygienists more independently cite concerns with patient safety and question whether it would significantly improve access to preventive dental care. Proponents argue that dental hygienists are trained to provide these services, and giving them more independence could improve access for underserved populations, such as Medicaid participants. Underserved populations may receive greater access to preventive dental care if dental hygienists were authorized to practice more independently.

How do Florida's laws differ from those of other states in authorizing hygienists to provide preventive dental care without dentist authorization?

Thirty states allow dental hygienists to initiate treatment based on their assessment of patients' needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and maintain a provider/patient relationship (see Exhibit 6). In Florida, a dental hygienist may provide treatment without a dentist's presence, but a dentist must first authorize the treatment.

Exhibit 6
Thirty States Allow Dental Hygienists to Provide Preventive Dental Care Without Prior Dentist Authorization[1]



[1] Rules allowing dental hygienists to provide preventive care without prior dentist approval are pending in Kentucky.

Source: American Dental Hygienists Association.

What are arguments for and against authorizing dental hygienists to practice more independently?

Opponents. Opponents' argue that dental hygienists are not trained to diagnose, and that practitioners need to know about patients' underlying medical conditions to safely provide preventive dental care. For example, some patients may need to take antibiotics before receiving routine dental care. In addition, dental hygienists are not required to carry malpractice insurance; thus, it is unclear who would be liable if a dental hygienist providing care in a health access setting became involved in a lawsuit. Dentists are currently liable for the care provided by their dental hygienists.

Opponents also argue that expanding the scope of practice for dental hygienists may not necessarily provide greater access to care in underserved areas. They cited a 2005 report sponsored by the American Dental Association that found there were only 17 independent dental hygienist practices in Colorado, which allows unsupervised dental hygiene practices. The report also concluded that the dental hygienists in independent practice do not tend to locate in rural areas or have fees significantly different from those of dental practices.

Proponents. Proponents of authorizing dental hygienists to practice more independently believe that patient safety would not be endangered and access to preventive dental care would be enhanced. These stakeholders contend that dental hygienists have sufficient training and education to safely provide preventive care. They assert that Florida has a critical shortage of dentists that provide preventive dental care to Medicaid participants and underserved areas and populations.

Further, proponents argue that allowing hygienists more independence could help improve patients' overall health. Research has linked periodontal disease to heart and lung disease; diabetes; pre-mature, low-birth weight babies; and a number of other systemic diseases. They assert that during oral health examinations, dental hygienists can detect signs of many diseases and conditions like HIV, oral cancer, eating disorders, osteoporosis, and diabetes. In addition, dental hygienists can work with patients to develop oral health care treatment plans that manage oral infection so it does not exacerbate serious diseases.

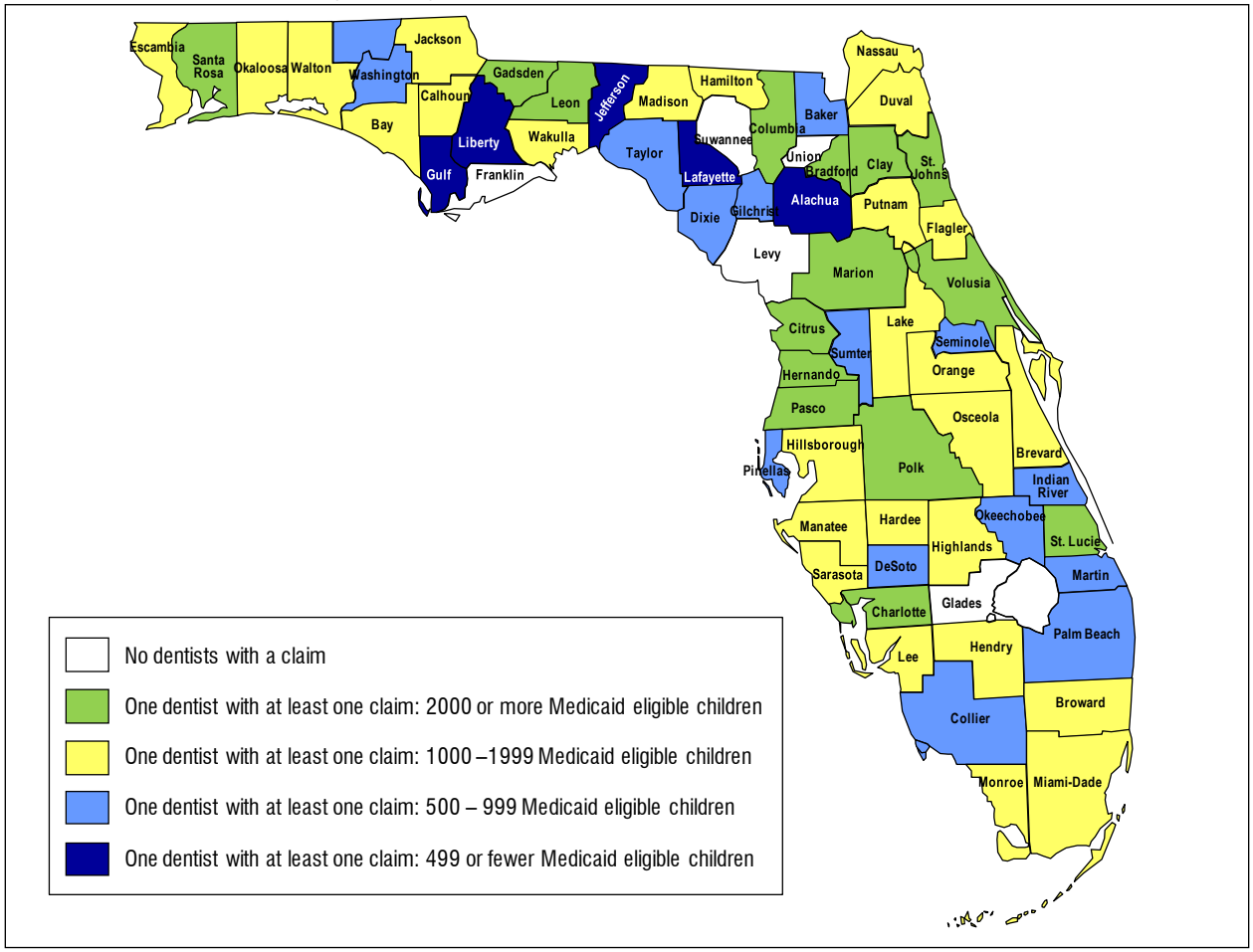
What are the potential effects on access to preventive dental care for Medicaid participants if Florida authorized dental hygienists to practice more independently?

Giving dental hygienists more authority to practice independently could provide underserved populations greater access to preventive dental care. Florida's Medicaid program covers preventive dental services for children from birth to 20 years old.[16] However, as shown in Exhibit 7, some rural counties lack dentists to serve Medicaid participants. For example, in Franklin, Glades, Levy, Suwannee, and Union counties, no dentists filed a claim with the Medicaid program during Fiscal Year 2008-09, although there were 10,797 children residing in these counties who were eligible for Medicaid dental services.[17] In addition, in 15 counties, 92 practices filed a dental claim with Medicaid, although 244,951 children were eligible for Medicaid dental services.

[16] During Fiscal Year 2008-09, Medicaid paid approximately $123 million for dental services, of which 6.5% ($8 million) was for preventive services such as cleanings, fluoride applications, sealants, and oral hygiene instructions. These claims included $22,116 paid to two Alabama dentists who treated Florida Medicaid patients.

[17] Due to variations in population density and other characteristics, the American Dental Association has not established a standard for the number of dentists per capita.

Exhibit 7
Access to Dentists Varies by County for Children Enrolled in Medicaid



Source: OPPAGA analysis of Medicaid data.

Statutory changes to supervision requirements for dental hygienists may also provide hygienists the ability to serve patients in settings that focus on underserved areas. These settings include programs and institutions of the Department of Children and Family Services, the Department of Health, and the Department of Juvenile Justice; nonprofit community health centers; Head Start centers; federally qualified health centers (FQHCs); FQHC look-alikes as defined by federal law; school-based prevention programs; clinics operated by accredited colleges of dentistry; and accredited dental hygiene programs.